A NEW AGENDA

Health and Social Service Strategies for Ontario's Seniors

Office for
Senior Citizens' Affairs
Mavis Wilson, Minister

"Our prime objective is to try to ensure that assistance becomes available to enable us to carry on an independent life – making our own decisions in our own homes for as long as possible. When an independent existence is no longer possible, we may be assured of the highest quality of life that residence in an institution can provide. We propose to do our part, but governmental and public support in our efforts is essential"

From a brief of the
United Senior Citizens
of Ontario to the Cabinet
Committee on Social Policy

March 27, 1986

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Preface

***The New Agenda** was originally released in June 1986 by Ontario's first Minister for Senior Citizens' Affairs, the Hon. Ron Van Horne. I am pleased to present this reprint of the White Paper.*

Mavis Wilson
Minister for Senior Citizens' Affairs
November 1987

By 2001 there will be approximately 1,400,000 people who are 65 years of age or older in Ontario. This will represent a 55% increase in this age group since 1983.* The greatest proportional growth will occur among senior citizens who are over age 75. The increase in the number of elderly citizens, and particularly the older elderly, is creating a new generation of issues which will have a profound effect upon provincial services.

Governments have a clear responsibility to respond to changing circumstances and to provide positive leadership in addressing major social and economic issues. The development of policies and programs to respond to an increasing elderly population, or indeed to the special needs of other members of society, clearly falls within this mandate. Recognition of this responsibility does not suggest that government either could, or should, "do it all". While governments must provide leadership and facilitate necessary changes, the development of appropriate responses has to involve the cooperation and assistance of all elements of our society.

Given the implications of demographic change, the Province initiated a comprehensive review of all senior citizen services in the fall of 1985. This report, which addresses health and social services, is the first of a series of papers on elderly programs. Subsequent papers will address issues such as income security, housing and transportation.

Throughout this report we have used the conventional definition of elderly persons, that is 65 years of age or older. However, the use of this convention is not intended to imply any stereotypical view that depicts senior citizens as being "old and sick" and segregates them from the main stream of our society. In fact, seniors are an extremely heterogeneous group with a wide range of needs. Most require no special services, some need assistance to enable them to continue to live in the community and a small group has needs which can only be met in institutional settings. It is necessary to recognize that the incidence of illness increases with age and this is reflected by increased use of health and social services, particularly by the older elderly.

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*Unless otherwise stated, 1983 is used as a baseline for all population projections and fiscal year 1983/84 is used for all financial estimates.

Nevertheless, the vast majority of seniors, including many in their eighties and nineties, live independently and are actively involved in their communities.

The Province's social goals for the elderly reflect the heterogeneous nature of our older population. They are:

- to improve and enhance the quality of life of Ontario's seniors;
- to ensure that elderly persons who require assistance to remain in their homes can obtain necessary community services; and
- to ensure that senior citizens who require institutional services receive appropriate and high quality care in a manner which respects their dignity and self-worth.

The primary objective of this paper is to outline a series of broad policy directions which would, in the view of the government, lead to a more effective and affordable system of health and social services for the elderly.* In effect, these broad policies represent a strategic plan for the progressive development of those services over the next 15 years. The question of how these policies can be achieved and implemented will be addressed through future consultation processes which will include the elderly, service providers and members of the public. Certain points might be noted regarding these strategies.

First, there is a perception that there has been an emphasis on institutional responses to the needs of the elderly, particularly in respect to long-term institutional settings such as extended care. Accordingly, the central theme of our proposals is to improve and/or maintain the health and functional status of the elderly (primarily through enhanced community care and services) and, thereby, to significantly reduce preventable and inappropriate institutionalization.

Second, this paper is based on the premise that an appropriate response cannot be achieved through a series of ad hoc and fragmented initiatives. Services for the elderly must be planned, implemented and delivered on a comprehensive or holistic basis.

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*These policies will also affect certain other groups which have similar or related needs. For example, many victims of Alzheimer's disease are not senior citizens.

Third, evolution is often based on the identification of existing and emerging issues and the subsequent creation of new strategies and methods. This process was used in the development of our new policy directions. Consequently, the paper focuses on areas in which further improvements or innovations are required. The identification of shortcomings in existing programs does not suggest that all services are unsound or require a total transformation. Nothing could be further from the truth. Ontario's health care is widely acknowledged as one of the finest in the world and its social services system has a reputation for leadership in the development of highly innovative and effective services. Nevertheless, we live in a rapidly changing world and we must continue to evaluate our current services and respond creatively to new circumstances.

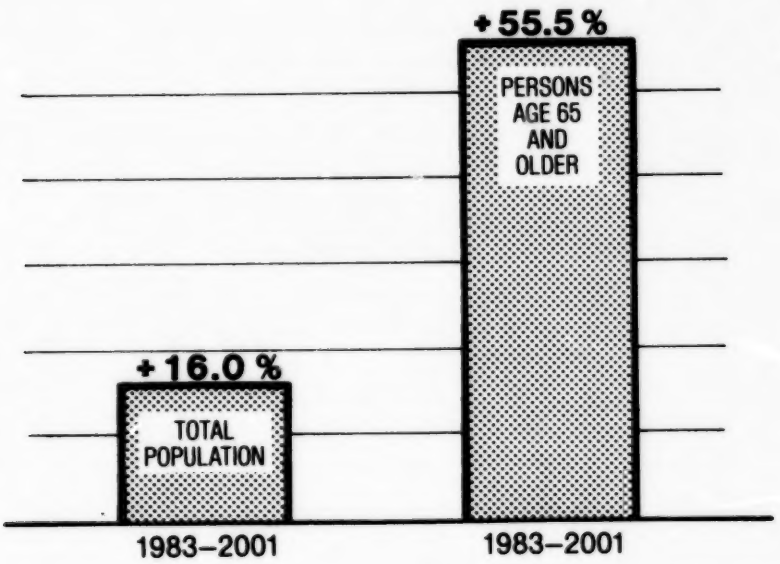
Finally, this report is not a technical paper, nor was it meant to be. It is rather a new agenda which is intended to meet the needs of Ontario seniors – now and in the future.

CHAPTER 1 *Background*

The effects of demographic change

Ontario is progressing through an extended period of major demographic change. The first phase occurred between 1960 to 1980, when the elderly increased from approximately 8 to 10% of the provincial population. This trend will continue until the year 2030 when the last of the baby boom reaches 65 years of age. At that time, seniors will represent an estimated 23% of the provincial population.

DIAGRAM 1 **Increase in the elderly population compared to the total population, 1983–2001**



Ontario is now in the second phase of a long-term demographic change. It is estimated that between 1983 and 2001 the number of senior citizens in the Province will increase by over 500,000,* or approximately 55%. During the same time period Ontario's total population will increase by approximately 16%.

In addition, average life expectancy has been steadily increasing and the elderly are living longer. Consequently, in the near future, our society will be affected not only by major growth in the total senior citizens' population, but also by unparalleled increases in the number of "older" elderly people. For example, current projections indicate that the number of persons who are 85 years of age or older will more than double by the year 2001.

*Almost half of this 500,000 increase in the elderly population will occur by 1991.

The use of the word elderly to describe all of our senior citizens may tend to obscure the significant differences which exist within this population. In general terms, the elderly can be viewed as being composed of three distinct age groups:

- the younger elderly, age 65 to 74, who represent 61% of the current seniors population;
- the middle elderly, age 75 to 84, who represent 30% of seniors; and
- the older elderly, age 85 and older who represent 9% of seniors.

It is necessary to recognize that variations exist within these age groups, as well as between them. Senior citizens, like younger persons, differ in their lifestyles, skills, interests and physical abilities.

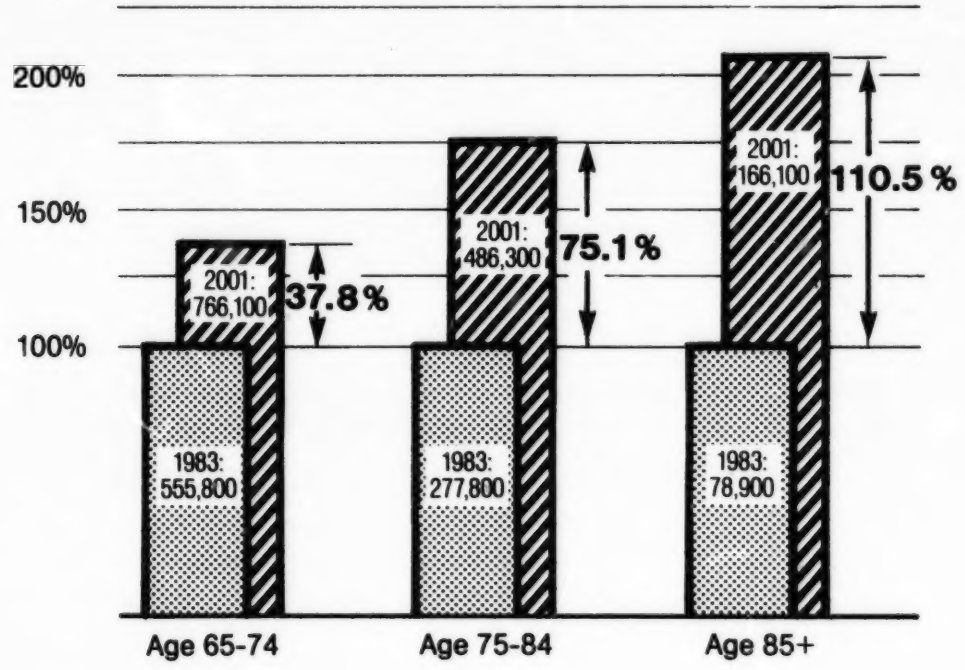
The younger elderly generally enjoy good health. Most of them have retired from the paid workforce and have the time to pursue various interests. Members of this age group typically lead active lives which include involvement in hobbies, sports, continuing education, religious and volunteer activities.

The middle elderly, too, are usually self-sufficient and pursue the normal activities of daily living. However, with advancing age, some inevitably begin to encounter difficulties coping with daily tasks or experience an increase in health problems. Others continue to be active and do not require any assistance.

The older elderly comprise the smallest segment of the senior citizen group. Many members of this age group continue to live in their own homes and participate in community life. However, people over age 85 are much more likely to be widowed, in frail health and require on-going assistance than individuals in the two younger sub-groups.

The composition of our elderly population will change dramatically by 2001. Although the total number of senior citizens will increase by approximately 55%, this growth will not be equally distributed among the elderly population, as illustrated by the following diagram.

DIAGRAM 2 **Relative growth of the three age groups of elderly people, 1983–2001**



By 2001, the number of persons age 65 to 74 will increase by approximately 38%, the number of persons age 75 to 84 will grow by 75% and persons over age 85 will increase by 110%. In other words, the greatest proportional increase will occur in the group which requires the most intensive level of service, that is those over age 85. As the life expectancy of females is longer than that of males, women will continue to represent the majority of the older elderly, and many of them will be living alone.

The pronounced growth in the absolute number of senior citizens, and particularly the older elderly, will require expansion of many existing services and will create a new generation of needs. This will have a profound effect on provincial services, particularly in health care.

Initial consultation

In June, 1985, a new government took office. One of its first acts was to designate the Hon. Ron Van Horne as Minister for Senior Citizens Affairs, with responsibility to guide the development of an appropriate, responsive and affordable system of services for the elderly.

Consistent with the new government's promise to create an open process for planning and program development, the Minister consulted with senior citizens, volunteers, service providers and members of the public. Meetings were held in every region of Ontario and included tours of community programs and facilities.

Participants in the consultation process commented on almost all aspects of Ontario's services to seniors, for example, income security, subsidized housing, recreational and transportation programs and, of course, health and social services. Given the breadth of seniors' programs, it was not possible to address all of these issues simultaneously. Accordingly, health and social services were selected as the first area for review as the participants indicated those services should be given the highest priority. Health and social services represent an estimated 75% of the more than $4 billion in provincial expenditures on identifiable services for the elderly in 1983/84. Following the initial public consultation, an intensive analysis was conducted with the full co-operation and assistance of the Hon. Murray Elston, Minister of Health and the Hon. John Sweeney, Minister of Community and Social Services.

CHAPTER 2 *A New Agenda*

Health and social services for the elderly can be divided into three major sectors: community care, hospital services, and long-term institutional care. Each sector is composed of a number of different components. Community care includes community health services, such as those provided by family physicians and the Home Care Program, plus a broad range of social services, for example, home-making, meals-on-wheels and adult day care. Hospital care encompasses all services provided on an inpatient or outpatient basis through acute, chronic or rehabilitation facilities. The major publicly-funded components of long-term institutional care are nursing homes and homes for the aged.

Given the diverse nature of the elderly population, and the wide variation in individual needs, it was necessary to review all health and social services for senior citizens. During the course of the review it became increasingly evident that although individual programs might be in entirely different sectors, or under different ministerial jurisdictions, they were all components of a broader service system. These programs are interdependent. As a result, problems arising in one area often impact on adjacent services. For example, gaps in community services may result in preventable admissions into hospital or long-term institutional care. Similarly, many hospitals encounter difficulties in discharging elderly patients who no longer require their services but cannot be safely discharged back to their own homes. That is, delays in obtaining access to appropriate long-term institutional care, may affect acute and chronic care hospitals.

Given the range of issues and the interdependent nature of seniors' services it is apparent that a more effective and responsive structure can only be developed through a comprehensive approach. Therefore, we are proposing five complementary directions or strategies which, together, address all elements of health and social services.

STRATEGIES

1. to improve and maintain the health and functional status of all Ontario's senior citizens through:
   - increased emphasis on health promotion and illness prevention; and
   - enhancing the quality of care through improvements in geriatric and gerontological education and research;
2. to maintain the frail elderly in the community by:
   - improving access to, and delivery of, community support services through the introduction of a one-stop-shopping approach; and
   - providing a broader and more innovative range of community support services;

3. to enhance the ability of hospitals to meet the needs of the frail elderly through improvements in specialized outreach and inpatient services;

4. to ensure that those persons whose needs cannot be met in the community receive appropriate and high quality long-term care; and

5. to facilitate the ongoing development of elderly services through comprehensive planning and management at both the provincial and local level.

The final strategy is essential to ensure on-going development and effective implementation of the other strategies.

All five strategies are intended to complement the three broad provincial policy goals for elderly people, namely: to improve the quality of life of Ontario's senior citizens; to ensure that elderly persons who require assistance to remain in the community can obtain appropriate services; and to provide high quality institutional services when this level of care is necessary.

CHAPTER 3 *Improvements in the Quality of Life*

The first broad provincial policy goal is to improve the quality of life for Ontario's senior citizens. Many factors influence quality of life, for example: adequacy of income, appropriate housing and opportunities for social and recreational activities. One of the most important determinants of quality of life is the individual's health and functional status. Consequently, initiatives which improve health, prevent deterioration or increase the likelihood of early detection and treatment of illness are important for the well-being of everyone.

Health promotion and illness prevention

Significant improvements in life expectancy and health status have been achieved over the last 50 years, primarily through improved public health and life-styles. Further improvement in both the physical and mental state of Canadians is most likely to be achieved in much the same way. While this idea has been generally accepted, it is not always recognized as being applicable to older people.

Experience has shown that better nutrition, more physical activity and more appropriate use of medications, can improve the well-being of the elderly. Furthermore, research suggests that health promotion activities begun in middle-age can improve health and functional status in later years. There is every evidence that today's seniors are actively interested in maintaining and improving their health and recognize that they, like everyone else, have a personal responsibility to do so.*

The government also has a responsibility to assist people to prepare for their later years and to maintain their health and functioning level. This can be encouraged and facilitated through health promotion and illness prevention programs.

We will initiate health promotion and illness prevention programs which specifically address issues relating to aging. We will also adapt existing prevention programs to the special needs of the elderly. Both will be developed in consultation with the elderly, professional groups and other interested parties.

As the rapid increase in the senior population is a national phenomenon, Ontario also intends to approach the federal government and the other provinces regarding the possibility of a co-operative national strategy for health promotion initiatives.

*For example, in March 1986 the Ontario Advisory Council on Senior Citizens, commenting on health issues, stated that "these concerns should focus the attention of everyone, from Senior Government to individual citizens, on the need to consider ways of preventing illness and staying healthy."

Promotion of a more positive image of the elderly

Older people are often portrayed as dependent and frail in spite of the fact that the majority live independent, active lives. This stereotype of the elderly may influence an older person's self-perception and reduce confidence in their own abilities. An holistic approach to good health includes social and emotional well-being. Social isolation and poor self-image can negatively affect the overall health of the elderly person. If we perceive the elderly, or lead them to perceive themselves, as no longer productive members of society, our, and their, responses will be limited by this perception.

A public education program will be initiated to encourage more positive attitudes towards aging and elderly people.

Education

Continued growth in the senior citizens' population and greater longevity necessitate a range of increasingly skilled professionals and related care givers who are sensitive to the special needs of the elderly. This need is not confined to any one group but relates to all major care providers for the elderly, for example: physicians, nurses, social workers, health care aides, and others.

The implications of an aging society have been recognized by Ontario's educational facilities and many have introduced improvements in geriatric and gerontological training in their curricula.

Given the rate of demographic change, it will be necessary to facilitate further improvements through:

- *enhancing geriatric training at both the undergraduate and post-graduate levels in all disciplines serving the elderly;*
- *assisting in the further development of continuing education programs for existing practitioners; and*

- *ensuring an adequate supply of geriatric specialists, for example, geriatricians, psychogeriatricians, geriatric nurses, audiologists and social workers. In pursuing this initiative, a high priority will be given to the development of francophone specialists.*

To support these activities and to complement the broader goal of excellence in education, we will establish, in consultation with the Council of Ontario Universities, a multi-disciplinary department of geriatrics at an Ontario university.

Research

In addition to an increase in the availability of skilled manpower, an effective service system for the elderly requires a better understanding of the aging process, related diseases, and the impact of different interventions.

To facilitate this process, we will encourage basic and clinical research on a priorized basis.

CHAPTER 4 *Community Services*

The most frequently expressed concern during the consultation process was that the absence of a comprehensive community services system results in preventable or unnecessary institutionalization. Accordingly, the government's first priority will be to enhance community care services.

Improvements in access and delivery of community services

Most senior citizens live independently in the community and will continue to do so. However, some will require assistance to maintain their independence. Generally, family and friends provide the most effective support for older persons. Nevertheless, it must be recognized that traditional assistance patterns have been affected by changing social conditions.

Historically, women who worked inside the home provided much of the family assistance to the elderly. Today, with more and more women working outside the home, the traditional family support system is often no longer possible. Growing mobility has resulted in family members being separated by considerable distances and the older children of the elderly may, themselves, be senior citizens. Consequently, some families will require assistance to maintain their elderly members in the community and some older persons will need more support than family or friends are able to provide. Given these circumstances, a responsive community services system is a necessity.

At the present time, community support services are provided by a wide variety of dedicated service agencies. These agencies have recognized the need for a more comprehensive approach and are all actively involved in service co-ordination. However, no single agency has either the mandate or the resources to conduct comprehensive functional assessments or to fully co-ordinate the delivery of a wide range of services for the elderly. Similarly, no agency has sole responsibility for monitoring changes in the individual's situation and arranging modifications in the range, type or intensity of services provided as the person's needs change.

Consequently, some senior citizens never have the benefit of a comprehensive assessment and others, or their families, go from agency to agency in an effort to obtain appropriate services. There is a need not only to improve access but also to provide a more comprehensive approach to the delivery of community health and social services.

We intend to assist the elderly to obtain appropriate services through the development of an integrated 'one-stop-shopping' approach which will:*

- *serve as a single point of entry for community services;*
- *provide comprehensive functional assessments;***
- *provide or arrange necessary services; and*
- *monitor and adjust services as needs change.*

This will not only be of direct benefit to the frail elderly and their families, but will also provide assistance to the family physician in obtaining necessary support services for their patients.

Consultation regarding the most effective means of developing a 'one-stop-shopping' or single access approach will occur before any initiatives are undertaken and it is anticipated that the initial developments will be on a pilot project basis.

Expansion and improvement of community services

While improvements in access and delivery of community services are essential, assisting senior citizens to remain in the community is also dependent upon the availability of an adequate range of community services in all parts of the Province.

The initial consultation process identified three primary needs in community services. These were:

- a need for more community services across the Province;
- a need for more innovative approaches to meet current and emerging needs; and
- a need for enriched funding for home support services.

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*The first step in the development of this approach was the New Homemaker Program which is delivered in conjunction with Home Care to provide the basis of a unified service approach.

**Medical assessments and services will continue to be provided by the senior citizen's physician.

The first steps to expand and improve community services were taken in January 1986 when the Province introduced the Integrated Homemaker Program for the Frail Elderly and Adult Physically Disabled. At the same time, an additional $11 million dollars was allocated for the enhancement of community services for the elderly, such as meals-on-wheels, escorted transportation and Older Adult Centres, and for increased support for volunteers who provide assistance to many of these programs.

We intend to progressively expand and improve community services with priority being given to northern, underserviced, rural and remote areas, in order to achieve a more uniform distribution across the Province. As part of this initiative, particular emphasis will be placed upon: enrichment of the funding base for home support services; the development of community support services for persons with Alzheimer's disease; improved community psychogeriatric services; innovative approaches to the provision of respite and senior day programs; and enhanced primary care in community health centers.

Special attention will be given to innovative programs which respond to the cultural needs of senior citizens in our francophone, ethnic and native communities.

Volunteers

Volunteers are one of our most important resources. When we speak of volunteers we are acknowledging two groups – those who work tirelessly with seniors on a volunteer basis and seniors themselves who devote many thousands of hours to worthwhile causes. Many community agencies could not operate effectively without their assistance.

The efforts of volunteers enhance the daily lives of many seniors by providing nutritious meals, transportation, assistance with household chores and home maintenance, visiting and many other services. Volunteers are not only major providers of services, but also are, in many cases, the critical link between house-bound seniors and their communities.

In recognition of their valuable contribution the government will, after appropriate consultation, undertake a number of further initiatives to support and expand the role of volunteers.

CHAPTER 5 *Hospital Services*

The elderly are the highest per capita consumers of hospital services and their consumption increases as they get older. In 1982/83 senior citizens represented approximately 10% of the population and consumed 40% of all days of acute hospital care. Ninety-five per cent of acute elderly patients in that year were discharged directly to the community after treatment for an illness or accident. Although hospitals are institutions they play a major role in the provision of community care as appropriate, high quality hospital services are essential for the maintenance of many of our elderly in the community.

Enhanced geriatric services

As more senior citizens are living longer, hospitals are becoming increasingly involved in the treatment and care of the older and often frail elderly. Many of these patients may present a complex diagnostic and treatment situation in which organic disease may be accompanied by functional impairments, social problems and, in some cases, emotional disorders. While recovery from surgical or medical treatment is more or less spontaneous for the majority of the younger elderly, this is not necessarily the case with frail elderly patients. An illness or accident may result in long-term institutional care if specialized geriatric and rehabilitation programs are not available.

Other countries, notably the United Kingdom, have pioneered methods to improve health care for the frail elderly. The United Kingdom has established geriatric assessment units which, although hospital-based, are primarily oriented toward maintaining the elderly in the community. This objective is achieved through community outreach programs, which reduce preventable or inappropriate institutionalization, and improvements in hospital programming, which increase the number of elderly who can be returned to the community following necessary treatment. They are led by a geriatrician and provide multi-disciplinary assessment, case consultation, staff training and assistance in developing geriatric services.

The introduction of these units has resulted in demonstrable decreases in preventable institutional admissions, improvements in quality of care, reductions in complication after illness or accidents, shorter lengths of stay in hospital and fewer blocked hospital beds.

Ontario's hospitals provide some of the best health care in the world and have a long tradition of responding to changing needs and continually improving their quality of care. In accordance with this tradition a number of Ontario hospitals have established geriatric and psychogeriatric assessment units and/or specialized geriatric programs such as day hospitals and outreach clinics. While some of these programs have received special grants from the Ministry of Health, many have been independent initiatives funded within the global budget of the hospital.

These services are not universally available throughout the Province at this time. For example, all of the existing geriatric assessment units are located in major centres and their service capacity has not been fully developed.

As part of its goals of improving the quality of care and assisting the elderly to remain in the community, the government intends to introduce specialized geriatric services on a regional basis throughout the Province.

Regional geriatric units will be established in designated community hospitals by enhancement of existing units and the development of new services. These units will be multi-disciplinary and will ultimately provide both geriatric and psychogeriatric services. They will operate as centres of geriatric expertise and provide specialized assessments and consulting services to affiliated hospitals, physicians and the community services system. All units will be affiliated with a teaching hospital.

As a complementary initiative, greater emphasis will be placed on the development of specialized outpatient and inpatient services for the elderly including day hospitals and outreach clinics. These services will be planned and developed on a regional basis.

In addition, all hospitals will be encouraged to introduce geriatric care committees and quality control programs and to ensure that discharge planning services are fully co-ordinated with the community services system.

Rehabilitation services for seniors

After an accident or illness many older or frail elderly people require specialized activation and rehabilitation services to maximize their functional level and to facilitate their return to the community. The need for these services will progressively increase in proportion to the population growth which is occurring among our older senior citizens. Chronic care hospitals have always had a rehabilitation role and these facilities have pioneered specialized rehabilitation and convalescent services for older people.

Our intention is to build upon this existing expertise by progressively expanding chronic care beds and placing greater emphasis on the development of rehabilitation and convalescent services for the elderly in chronic care facilities and selected chronic care units in active treatment hospitals. The feasibility of establishing regional rehabilitation centres for the elderly will also be fully explored.

CHAPTER 6 *Long-term Institutional Care*

Long-term institutional care encompasses extended care and residential care. Extended care is a health-insured service for persons who cannot be maintained in the community and who require a minimum of one and one half hours of nursing care per day. Slightly more than 70% of the approximately 42,000 existing extended care beds are provided through nursing homes. The remainder are in municipal and charitable homes for the aged.

Many homes for the aged also provide residential care, a service which provides room, board and supervision to persons who do not require extensive nursing and personal care. There are approximately 14,000 subsidized residential care beds in Ontario.

Extended care in nursing homes and homes for the aged

During the initial consultation process the majority of concerns regarding long-term institutional care were focused on extended care. They touched upon almost all aspects of the current program. The chief concerns were:

- a perception that many elderly persons who are in extended care facilities could be maintained in their homes if appropriate services were available;
- reservations regarding quality of care and inspection services, particularly in nursing homes;
- that there is a lack of consistency in the current extended care program. Three different types of providers operate under different legislation, funding mechanisms, staffing requirements, standards of care and inspection processes;
- representations from extended care providers that funding is not adequate to meet the needs of an increasing number of 'heavy care' residents;
- the adequacy of current legislation with respect to issues regarding enforcement, accountability, transfers of nursing home licenses, and others; and
- that there is a lack of suitable alternatives for persons who are not appropriately served by the extended care program.

Two points might be noted with respect to these concerns. First, all of the strategies which have been previously discussed – health promotion, education and research, community services, and enhancement of hospital services – are specifically intended to reduce and, ideally, to eliminate preventable and inappropriate institutionalization. However, although these initiatives will significantly enhance the ability of the frail elderly to remain in their communities, some elderly persons will have needs which can only be met in institutional settings.

Second, the extended care program was introduced in 1972 to address the needs which existed at that time. There have been major changes since then. To cite one example: the age of admission to the program has progressively increased over the past 14 years and the average age of applicants is now 83.* The program has been improved over the years. However, new needs require new solutions and these cannot be attained entirely by incremental improvements.

We will undertake a major revision and rationalization of the extended care program and also address complementary issues in adjacent services such as residential care and rest homes.

The central initiative will be the development of new extended care legislation. The intent is to develop a single, improved act which will apply to all providers and establish uniform criteria in such areas as inspection services, programming, staffing, quality of care and physical plant standards.

In the development of this legislation particular attention will be devoted to improved standards of care and activation, more effective controls and increased accountability. Consideration will also be given to such issues as community involvement and volunteers, emerging topics such as 'continuing care communities', the feasibility of moving towards a more uniform system of funding for extended care and improved assessment and placement procedures. This process will involve appropriate consultation with all affected parties.

As a complementary initiative, we will proceed with a joint provincial /service provider review of current and emerging care requirements.

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*Presumably this reflects not only increased longevity, but also improvements in health and social services which have been introduced over the years.

Finally, it is clear that the extended care program was not designed to meet the particular needs of some of the elderly, for example confused ambulatory persons. Increasingly, their families are encountering difficulty in obtaining access to appropriate services.

Consideration will be given to developing more innovative and appropriate responses to the needs of these seniors.

Residential care

Residential care in charitable and municipal homes for the aged normally consists of room, board, supervision and a wide range of social and recreational programs. In recent years the demand for residential care appears to have decreased in some areas. This seems to be the result of factors such as improved health status and the availability of community services.

The reduction in demand for residential care has been accompanied by proposals to convert existing spaces in charitable and municipal homes for the aged to extended care beds. While some trends would appear to support these proposals, the future requirement for residential care beds is not clear at this time.

We will initiate a review of current and future residential care requirements.

CHAPTER 7 *Rest Homes*

There is no official definition of rest homes*. The term is used to refer to a wide variety of settings, operated primarily by the private sector, ranging from residential care with minimal supervision to luxury retirement complexes offering extensive personal care and recreational activities.

Currently, there are no provincial guidelines or regulations establishing the standards of care in rest homes although they are subject to public health standards, and fire and building regulations. Some municipalities have addressed this situation by enacting special by-laws, however, the issue has not been adequately resolved throughout the Province.

There is a general concern regarding the absence of legislation to ensure adequate standards of care in rest homes. This situation cannot be allowed to continue. The issue is extremely complicated and the best method of resolving this is not readily apparent.

The government will explore all appropriate options to ascertain the most effective means of addressing this issue and take the necessary steps to ensure that rest homes are subject to appropriate regulation.

This initiative will complement the activities of the Task Force on Roomers and Boarders which was established on March 27, 1986, by the Minister of Housing. The Task Force will address the need for improved regulations to protect roomers, boarders and lodgers and recommend ways to increase the supply of affordable housing for low income single individuals.

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*These homes are also referred to as retirement homes and the Rest Home Association of Ontario has changed its title to the Ontario Long-Term Residential Care Association.

CHAPTER 8 *Comprehensive Planning and Management*

Successful implementation of the strategies discussed in the previous chapters requires comprehensive planning and management at both the provincial and local level. Currently, health and social services for the elderly come under the jurisdiction of two different ministries which have different basic philosophies, legislative requirements, approaches to determining the need for services and funding formulas. At the local level, there is also no single focal point for the development and management of services for the elderly. During the first consultation process there was a strong consensus that services for senior citizens must be developed and planned on a comprehensive basis. This consensus emphasizes the interdependence of the various parts of the system and the need for their co-ordination.

Planning and management at the provincial level

Many participants in our first consultation process expressed the opinion that the current division of responsibility between the Ministry of Health and the Ministry of Community and Social Services had contributed to a fragmented approach to services for the elderly.

As a first step, the government has placed responsibility for comprehensive planning and overall co-ordination of services for the elderly with the Minister for Senior Citizens' Affairs. This mandate includes a review of other provincial elderly services such as income security, housing, transportation and recreation.

Planning and management at the local level

While the benefits of a comprehensive provincial approach are apparent, the real effectiveness of a service system is measured by its ability to respond to the needs of individuals in their own community. At the present time, no single agency has the responsibility or the authority to plan, develop and manage local services for the elderly. The result is an ad hoc approach, which cannot fully respond to the overall needs of our senior citizens.

Effective community services are essential to support our objective of maintaining the elderly in the community. Therefore, the most logical area to initiate local planning and management is in the community services sector. This might be accomplished through:

- a special purpose board which is directly responsible to the Province;
- local government; or
- a provincial ministry with responsibility delegated to local offices.

Given the diversity which exists within Ontario, one option might meet the needs of a densely populated urban centre while a different mechanism would be more appropriate in a rural area with a widely distributed population.

We intend to explore the feasibility of vesting local authorities with responsibility for planning and managing community services. Extensive consultation with interested parties and further study will be required before any initiatives are undertaken.

Summary Statement

The government's broad social goals for the elderly are: to improve the quality of life and health of Ontario's senior citizens; to ensure that elderly persons who require assistance to live in the community can obtain necessary services; and to ensure that seniors whose needs cannot be met in the community, receive appropriate, high quality long-term care in a manner which recognizes their dignity and values.

We believe that these goals cannot be achieved through a series of ad hoc initiatives but require a comprehensive approach which addresses all major aspects of the health and social services system for the elderly.

This paper identifies five broad complementary strategies and a number of specific initiatives designed to address current concerns and future needs. In total, these strategies represent an outline of a strategic plan for policy and program development in health and social services for the elderly over the next fifteen years.

Time will be required to fully develop a new system. New and expanded programs must be built on a solid fiscal foundation and we all have a responsibility to ensure that the pace of development is consistent with our economic capacity.

It will also take time to develop the most effective service models and to increase the supply of geriatric and gerontological care providers. Nevertheless, we can establish realistic priorities and progressively develop a system which will fulfill our commitment to our senior citizens.

However, we cannot do it alone. While the directions for the future are clear, we will need the advice of our senior citizens, the expertise of our service providers and professional associations, and the support and assistance of the public to develop and implement these strategies. To facilitate appropriate consultation we are proposing a three-stage process:

- a first phase of consultation in communities across the Province which will take place soon after this paper is released;
- a second phase involving professional and other associations, and
- a third phase which will involve direct consultation with all affected parties on specific priorized issues.

It is our belief that through co-operative action, Ontario will be able to develop "an effective, affordable and sensitive system of care"* for our senior citizens.

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*The Honourable David Peterson, Premier of Ontario, Toronto, July 2, 1985.